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FACILITY FEES AND ACCOUNTABLE CARE ORGANIZATIONS

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ISSUE

This report answers a series of questions on (1) how the Center for Medicare and Medicaid Services (CMS) regulates facility fees (particularly fees charged by hospital-based outpatient facilities) and (2) accountable care organizations.

1. How does CMS define facility fees and what costs do they cover?

Hospitals, hospital-based facilities (such as outpatient clinics owned by a hospital), and various other medical facilities often charge a facility fee as well as the provider's professional fees. CMS regulations do not establish a general definition of "facility fee," but CMS sets reimbursement rates for these fees subject to various requirements set forth below. The facility fee covers overhead costs, such as equipment, space, and support staff. This fee is sometimes referred to as the technical component of the bill.

2. How does CMS define a facility for billing purposes and determine which practices can bill for facility fees?

Under the CMS "provider-based status" rules, Medicare will reimburse for facility fees at a hospital-based facility (such a group practice owned by the hospital) meeting certain requirements but not at physicians' offices not affiliated with a hospital.

A facility or practice has provider-based status and thus can bill for facility fees it if has a relationship with the main provider (i.e., the hospital) concerning a range of issues, such as licensure, clinical and financial integration with the hospital, public awareness, and billing practices. The regulations specify payment recovery procedures if a hospital inappropriately treats a facility as provider-based (42 CFR § 413.65(j)).

Below, we provide more information on the provider-based status requirements (42 CFR § 413.65). Some provisions of the regulations are complex, and this report does not describe all details (e.g., we do not discuss additional requirements regarding facilities operated as joint ventures).

Facility Types (42 CFR § 413.65(a))

These provider-based status rules apply to various types of entities, including provider-based entities, departments of a provider, remote locations of a hospital, and satellite facilities.

CMS regulations define these terms. For example, a "provider-based entity" is generally defined as a provider of health care services that is created by, or acquired, by a main provider (i.e., a hospital) to furnish different health care services from those of the main provider, under the main provider's ownership and administrative and financial control, in accordance with the requirements set forth below. The term includes both the (1) specific physical facility that serves as the site of services that could be reimbursed under Medicare or Medicaid and (2) personnel and equipment needed to deliver those services at the facility.

A provider-based entity, by itself, may be qualified to participate in Medicare as a provider and the Medicare Conditions of Participation apply to a provider-based entity as an independent entity. The CMS Conditions of Participation set health and safety standards for health care organizations participating in Medicare and Medicaid.

For another example, a "department of a provider" is a facility or organization created by, or acquired by, a main provider to furnish health care services of the same type as those furnished by the main provider under the main provider's name, ownership, and financial and administrative control, in accordance with the requirements below. As with a provider-based entity, the term includes both the physical facility and the personnel and equipment. In contrast to a provider-based entity, a department of a provider may not by itself be qualified to participate in Medicare as a provider and the Medicare Conditions of Participation do not apply to a department as an independent entity.

General Requirements (42 CFR § 413.65(d))

Licensure. The facility must be operated under the same license as the main provider (i.e., the hospital), unless the state requires a separate license or does not permit the outpatient facility and hospital to be licensed under a single license.

Clinical Services. The clinical services of the facility and the hospital must be integrated as shown by several criteria. Among other things, (1) the facility's professional staff must have clinical privileges at the hospital, (2) the hospital must maintain the same monitoring and oversight of the facility as it does for its other departments, and (3) facility patients requiring further care must have full access to all hospital services and be referred when appropriate to the hospital's corresponding department or service.

Financial Integration. The financial operations of the facility must be fully integrated within the hospital's financial system, as evidenced by shared income and expenses. The facility's costs must be reported in a cost center of the hospital and the facility's financial status must be incorporated and readily identified in the hospital's trial balance.

Public Awareness. The facility must be held out to the public and other payers as part of the hospital. When patients enter the facility, they must be aware that they are entering the hospital and billed accordingly.

Requirements Specific to Hospital-Based Facilities (42 CFR § 413.65(g))

Emergency Medical Treatment and Active Labor Act (EMTALA). Any on-campus facility treated by Medicare as a hospital department, or off-campus facility treated by Medicare as a hospital department and that is a dedicated emergency department, must comply with various "antidumping" provisions in EMTALA. (Dumping refers to hospitals turning away uninsured or indigent people seeking treatment.)

Billing Site-of-Service Code. Physician services furnished in hospital outpatient departments or most other hospital-based entities must be billed with the correct site-of-service so the appropriate physician and practitioner payment amounts can be determined.

Provider Agreement. Hospital outpatient departments must comply with all the terms of the hospital's provider agreement.

Non-Discrimination. Physicians who work in hospital outpatient departments or hospital-based entities must comply with various non-discrimination provisions.

Billing as Outpatients. For billing purposes, most hospital outpatient departments must treat all Medicare patients as hospital outpatients.

Payment Window. If a patient is admitted to the hospital as an inpatient after being treated in a hospital outpatient department or another hospital-based entity, payment for services at the first facility is subject to certain "payment window" provisions (i.e., specified services within the three days prior to admission are considered to be inpatient services for payment purposes).

Notice of Coinsurance Liability. When a Medicare beneficiary is treated in a hospital outpatient department not located on the hospital's campus and the patient will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician's service, the hospital must provide written notice of that financial liability. The notice must generally be provided before the services are provided (there are exceptions, such as in an emergency).

The regulations specify the content of the notice, including the amount of the potential financial liability or an estimate based on typical or average charges for facility visits if the exact type and extent of necessary care is unknown.

Health and Safety Rules. Hospital outpatient departments must meet applicable hospital health and safety rules for Medicare-participating hospitals.

Additional Requirements for Off-Campus Facilities (42 CFR § 413.65(e))

Facilities not located on the hospital's campus (generally defined as those located more than 250 yards from the hospital's main buildings) must also meet the following requirements to be considered as having provider-based status.

Ownership and Control by the Hospital. The facility must be operated under the hospital's ownership and control, as shown by the following.

1. The facility is 100% owned by the hospital.
2. The facility and hospital have the same governing body and are operated under the same organizational documents.
3. The hospital has final responsibility for the facility's administrative decisions; final approval for its outside contracts, personnel actions, and medical staff appointments; and final responsibility for personnel policies.

Administration and Supervision. The reporting relationship between the facility and hospital must have the same frequency, intensity, and level of accountability that exist in the relationship between the hospital and its existing departments, as shown by compliance with the following.

1. The facility is under the hospital's direct supervision.
2. The facility is operated under the same monitoring and oversight by the hospital as its other departments and is operated just as any other department with regard to supervision and accountability. (The rules specify certain requirements for the facility's director.)
3. The following administrative functions of the facility are integrated with those of the hospital: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. These functions must be (a) handled by the same employees or group of employees; (b) contracted out under the same contract agreement; or (c) handled under different contracts, with the facility's contracts being managed by the hospital.

Location. The facility must be located within a 35-mile radius of the hospital's campus or meet other specified conditions. For example, the facility can also qualify if it:

1. is owned and operated by a hospital that meets specified criteria regarding service to indigent patients or
2. demonstrates that it serves the same patient population as the main hospital (e.g., at least 75% of the facility's patients live in the same zip code areas as at least 75% of the hospital's patients).

Other criteria apply to certain types of facilities outside of the 35-mile radius.

3. How does CMS regulate facility fee charges and have there been any significant changes in the regulations in recent years? Do the charges vary based on the complexity or type of the procedure or facility?

CMS sets Medicare reimbursement rates for facility fees, with different rates schedules for different facility types (e.g., hospital emergency department, hospital outpatient clinic, and ambulatory surgical center) and procedures. For example, CMS sets rates for designated hospital outpatient services through its Hospital Outpatient Prospective Payment System (OPPS) (42 USC § 1395l). CMS must annually review and adjust these payment rates. (See this fact sheet for an overview of the OPPS.) Whether the reimbursement rate varies by complexity of care depends on the type of facility.

For example, one recent significant change to these regulations concerned acuity-based reimbursement levels for hospital outpatient visits. CMS amended its regulations in 2013 to create a single reimbursement code for facility fees for hospital outpatient clinic visits for assessment and management of patients, effective January 1, 2014 (78 Fed. Reg. 74826, 75038 (Dec. 13, 2013)). Under the

previous system, CMS established five levels of reimbursement for hospital outpatient clinic visits based on the level of service provided, with different codes for new or established patients. For 2014, the single reimbursement rate is $92.53. Under the five-level system in 2013, the reimbursement rate varied from (1) $56.77 to $175.79 for new patients and (2) $56.77 to $128.48 for established patients.

By contrast, CMS continues to reimburse for emergency department facility fees on a five-level reimbursement system. CMS had proposed similar changes for emergency departments as for outpatient clinics but did not enact the proposal.

For purposes of the five reimbursement levels for emergency departments (and under the former policy for outpatient clinics), CMS requires hospitals to develop internal guidelines for reporting the appropriate visit level. The guidelines should "reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes" (78 Fed. Reg. 74826, 75038).

4. What are Medicare Accountable Care Organizations (ACOs)?

Medicare ACOs are voluntary networks of doctors, hospitals, and other health care providers that coordinate care for Medicare patients (excluding those enrolled in Medicare Advantage (Part C) private plans). The federal Affordable Care Act (P.L. 111-148 § 3022) authorized the use of ACOs as a way to improve patient care and reduce health care costs in the Medicare program. (Providers may participate in a Medicare ACO and commercial payer ACO at the same time.)

ACOs assume medical and financial responsibility for their Medicare patients' care. While they still use Medicare's traditional fee-for-service (FFS) payment system, ACOs are eligible for additional payments or bonuses when providers coordinate care, reduce Medicare spending, and meet specified quality of care benchmarks. These benchmarks address (1) patient and caregiver experience; (2) care coordination; (3) patient safety; (4) preventive health; and (5) at-risk populations, which include diabetes, coronary artery disease, and hypertension, among others.

Providers participating in an ACO must notify their patients, who can then choose to receive care from another provider if they do not want to participate. Additionally, patients may decline to have their protected health care information shared with an ACO.

According to CMS, Medicare offers three ACO programs: (1) Medicare Shared Savings (MSSP), (2) Advanced Payment ACO Model, and (3) Pioneer ACO model.

MSSP

Under the MSSP, providers must participate for three years and care for a minimum of 5,000 Medicare FFS (Part A and Part B) beneficiaries. ACOs may choose to either (1) share in up to 50% of Medicare savings with CMS or (2) assume greater risk and share in up to 60% of both savings and losses.

According to CMS, during the program's first performance year, 53 out of 220 participating ACOs held spending at $652 million below their targets and earned approximately $300 million in shared savings payments. An additional 52 ACOs reduced health care costs compared to their benchmark but did not qualify for shared savings because they did not meet the minimum savings threshold. The program generated approximately $345 million in savings to the Medicare Trust Funds.

CMS notes that one ACO participating in the higher risk model exceeded its spending target by $10 million and owed shared losses of $4 million. All participants improved on 30 out of 33 quality of care measures, such as patient experience, health promotion and education, and screening for high blood pressure and tobacco use.

Advanced Payment ACO Model

The Advanced Payment ACO Model is designed to help ACOs sponsored by physicians or rural providers to participate in the MSSP. Program participants receive advanced monthly payments to invest in the infrastructure necessary to provide coordinated care.

Pioneer ACO Model

The Pioneer ACO Model is designed for health care providers already experienced in operating as an ACO or in similar arrangements. Providers must enter into a three-year agreement to care for at least 15,000 Medicare beneficiaries. CMS may extend the agreement for an additional two years based on the ACOs' performance and preference.

During the first two years of the program, the ACO enters into a shared savings payment arrangement with CMS with higher levels of savings and risk than in the MSSP. Beginning in the third year, ACOs that meet certain performance benchmarks are eligible to transition away from a FFS payment to a population-based payment (e.g., per-member-per-month payment) and full-risk arrangement that can continue for the remainder of their participation in the program.

According to CMS, 13 of 32 ACOs participating in the program in its first performance year in 2012 produced shared savings with CMS, generating approximately $33 million in savings to the Medicare Trust Funds. All 32 participants earned incentive payments for reporting on all of the program's 15 quality of care benchmarks.

During the program's second performance year, Pioneer ACOs qualified for $68 million in shared savings payments and saved the Medicare Trust Fund approximately $41 million. According to CMS, the mean quality score among Pioneer ACOs increased by 19 percent, from 71.8 percent in 2012 to 85.2 percent in 2013.

Nine ACOs left the program in 2013, seven of which instead applied to the MSSP. The Pioneer ACO Model program currently has 19 participants and is no longer accepting new applicants.

5. How many Medicare ACOs are in Connecticut?

According to the CMS website, there are currently 337 ACOs participating in the MSSP, including five in Connecticut. Two of these ACOs (MPS ACO Physicians, LLC and PriMed LLC) also participate in the Advanced Payment ACO program. There are no Connecticut ACOs participating in the Pioneer ACO Model program. Table 1 lists Connecticut's Medicare ACOs. (This list may not be exhaustive.)

Table 1: Connecticut's Medicare ACOs

Name	*Address*	*Medicare program*
Hartford Healthcare ACO, Inc.	200 Retreat Ave., Hartford, CT	MSSP
MPS ACO Physicians, LLC	31 Crescent St., Middletown, CT	MSSP and Advanced Payment ACO
PriMed, LLC	3 Enterprise Dr. Ste. 404, Shelton, CT	MSSP and Advanced Payment ACO
ProHealth Physicians ACO, LLC	4 Farm Springs Rd., Farmington, CT	MSSP
Saint Francis HealthCare Partners ACO, Inc.	95 Woodland St. 4th Floor, Hartford, CT	MSSP

Source: CMS, https://data.cms.gov/browse?category=ACO&utf8=

6. How have ACOs contributed to the expansion of facility fees in Connecticut?

We were unable to find any information that directly links ACOs to Connecticut's facility fees. Generally, proponents cite ACOs as a model for reducing unnecessary health care spending while improving quality of care by making the whole team of health care providers responsible for a patient's care. However, opponents express concerns that ACOs may create an increase in consolidations between hospital

systems and physician practices, resulting in (1) a reduction in the number of independent hospital and doctors and (2) an increase in patients' health care costs, including facility fees, by physicians who were previously unable to assess them.

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